REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of Patient: _____
(please print)

Date of Birth: _____

I request that all communications to me (by telephone, mail or otherwise) by _____ [insert name of Practice] and/or its staff be handled in the following manner:

- For written communications: Address to: _____
  _____
  _____
  _____
- For oral communications: Call: _____
  (telephone number)
  May we leave a message?
  Yes ☐ No ☐

If the address provided above is not your home address or is not a street address, please provide us with a street address for purposes of ensuring payment:

_____
_____
_____

_____
Patient Signature

_____
Date

For Practice Use Only

Practice: ☐ Accepts ☐ Denies	
Privacy Officer Signature:	_____
Date:	_____